Restorative Dental

PATIENT INFORMATION

DATE _____

NAME _____ ❑Married ❑Single ❑Minor ❑Male ❑Female
LAST FIRST M/I

ADDRESS _____ DATE OF BIRTH ___/___/___
STREET APT. # CITY STATE ZIP MONTH DAY YEAR

EMAIL ADDRESS _____ SSN _____

TELEPHONE: HOME ( ) _____ WORK ( ) _____ CELL ( ) _____

IF FULL-TIME STUDENT, NAME OF SCHOOL _____ GRADE _____

Has any member of your family been treated in our practice? ❑YES ❑NO WHO? _____

Whom may we thank for referring you to our dental practice? _____

FAMILY INFORMATION

PRIMARY GUARANTOR

_____
LAST FIRST M/I

_____
STREET CITY STATE ZIP

_____
HOME TELEPHONE WORK TELEPHONE

_____
BIRTH DATE (MO/DAY/YEAR) SSN

_____
EMPLOYER

_____
DENTAL INSURANCE CO. GROUP #

SECONDARY GUARANTOR

_____
LAST FIRST M/I

_____
STREET CITY STATE ZIP

_____
HOME TELEPHONE WORK TELEPHONE

_____
BIRTH DATE (MO/DAY/YEAR) SSN

_____
EMPLOYER

_____
DENTAL INSURANCE CO. GROUP #

ACKNOWLEDGMENT AND AUTHORITY

- The information on this page and the dental/medical histories are correct to the best of my knowledge.
- I hereby authorize the dentist to administer such medications and perform such diagnostic and therapeutic procedures as may be necessary for proper dental care.
- I hereby authorize payment directly to the Dental Office of the group insurance benefits otherwise payable to me.
- I understand the dentist may release my dental, medical and other information about my dental treatment to third party payors and/or other health professionals in accordance with HIPPA regulations.
- I acknowledge full responsibility for the payment of all fees for services rendered. If desired, Restorative Dental Associates will file a claim on your behalf with your insurance company. I understand that I am responsible for any collectable charges that my insurance company denies payment. In addition, I agree to pay my deductible and any patient portion due at the time of service.
- I have received a copy of the HIPAA Privacy Policy as required by law.
- I prefer to be contacted via ❑ home phone ❑ work phone ❑ email and ❑ US Mail (check all that apply).

X_____
❑Adult Patient ❑Parent or Step-Parent ❑Guardian

_____ _____
Date State / Driver's License #

PERSON TO CONTACT IN CASE OF EMERGENCY

Outside of Immediate Family / Household

Name_____
Address_____
City/State/Zip _____
Telephone # (_____) _____

PERSON RESPONSIBLE FOR ACCOUNT

Please check one

❑Patient ❑Husband (or Father)
❑Guardian ❑Wife (or Mother)

Responsible party has an account with this office: ❑Yes ❑No

METHOD OF PAYMENT (unless otherwise arranged)

❑ I will pay in full at each appointment via
❑Cash or Check ❑Visa ❑MC ❑AmEx ❑Disc

Card # _____ Exp _____

_____ I understand I am responsible for all charges incurred for services rendered, including any charges that are ultimately denied by my insurance company. I will pay my deductible and any patient portion owed at the time of service.

Restorative Dental

PATIENT HEALTH INFORMATION

Date _____

Name _____
LAST FIRST M/I

What is the primary reason for your visit today?: ❑ Comprehensive Exam ❑ Emergency Treatment

ORAL HEALTH INFORMATION

Please explain any "Yes" in space to the right or in Remarks.

1. When was the last time you saw a dentist? Dentist Name: _____ When (mo/yr): _____
2. Are any of your teeth sensitive to hot, cold, biting pressure, or sweets? ❑Yes ❑No _____
3. Do your gums bleed when your brush or floss? ❑Yes ❑No _____
4. Have you ever been told you have periodontal (gum) disease? ❑Yes ❑No _____
5. Are there areas in your mouth you avoid chewing on? ❑Yes ❑No _____
6. Have you had complete set of x-rays in the past year? ❑Yes ❑No _____
7. Do your jaw joints (TMJ) click, pop, or cause pain? ❑Yes ❑No _____
8. Are you aware of any nighttime clenching or grinding of your teeth? ❑Yes ❑No _____
9. Do your teeth show signs of chipping and/or wear? ❑Yes ❑No _____
10. Have you ever had problems with past dental treatments? ❑Yes ❑No _____
11. Are you missing any teeth? ❑Yes ❑No _____
12. Do you have a replacement for missing teeth? ❑Cemented Bridge ❑Removable Partial ❑Full Denture ❑Implants

MEDICAL HEALTH INFORMATION

Please explain any "Yes" in space to the right or in Remarks.

1. Physician _____ Date last seen _____ Height _____ Weight _____
2. Are you under a physician's care now? ❑Yes ❑No _____
3. Any hospitalization in the past 5 years? ❑Yes ❑No _____
4. Have you had any serious illnesses or operations? ❑Yes ❑No _____
5. Are you taking any medications, pills or drugs? ❑Yes ❑No _____
6. Are you allergic to anything? ❑Aspirin ❑Penicillin ❑Codeine ❑Novocain ❑Latex ❑Metals ❑Other_____ ❑No allergy
7. WOMEN (Please check if applicable) ❑Pregnant (Due date _____) ❑Nursing
8. Do you use any of the following? ❑Cigarettes/Cigar/Pipe ❑Chewing Tobacco ❑Snuff ❑Alcohol ❑Recreational Drugs
9. Do you have, or have you ever had, any of the following? (Please check and describe below):

Yes	No		Yes	No		Yes	No	
❑	❑	Any heart problem	❑	❑	Emphysema/COPD	❑	❑	Osteoporosis
❑	❑	Abnormal bleeding	❑	❑	Tuberculosis	❑	❑	Artificial joints
❑	❑	Anemia	❑	❑	Sinus problems	❑	❑	Cancer/malignancy
❑	❑	High blood pressure	❑	❑	Allergy	❑	❑	Chemotherapy
❑	❑	High cholesterol	❑	❑	Reflux/heartburn	❑	❑	Radiation treatments
❑	❑	Fainting or dizziness	❑	❑	Hepatitis	❑	❑	Sexually transmitted disease
❑	❑	Stroke	❑	❑	Liver disease	❑	❑	HIV or AIDS
❑	❑	Epilepsy or seizures	❑	❑	Kidney disease	❑	❑	Drug or alcohol problem
❑	❑	Frequent headaches	❑	❑	Diabetes	❑	❑	Coumadin®/warfarin/aspirin therapy
❑	❑	Psychiatric problems	❑	❑	Thyroid problems	❑	❑	Antibiotic premedication
❑	❑	Asthma	❑	❑	Arthritis	❑	❑	Bisphosphonates (Fosamax®, Actonel®, others)

10. Do you know of any reason why routine dental procedures might pose a risk to you, the dental staff, or other patients? ❑Yes ❑No
11. Is there anything important about your medical condition we have not asked? ❑Yes ❑No _____

Remarks _____

To the best of my knowledge, all of the preceding answers are correct. If I have any changes in my health status or if my medications change, I shall inform the dentist and staff at the next appointment without fail.

Signature_____ Date _____